



HEALTH POLICY

KHYBER PAKHTUNKHWA



DEPARTMENT OF HEALTH
KHYBER PAKHTUNKHWA

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LIST OF ACRONYMS AND ABBREVIATIONS

ANC	Antenatal care
ARI	Acute Respiratory Infections
ATLS	Advance Trauma Life Support
BCLS	Basic Cardiac Life Support
BEmONC	Basic Emergency Obstetric and Newburn Care
BHU	Basic Health Unit
BISP	Benazir Income Support Programme
BoD	Burden of Diseases
CMAM	Community Management of Acute Malnutrition
CME	Continuing Medical Education
CMW	Community Mid Wife
CPD	Continuous Professional Development
CPR	Contraceptive Prevalence Rate
DFID	Department for International Development
DHDC	Divisional Health Development Centres
DGHS	Director General of Health Services
DHO	District Health Officer
DHIS	District Health Information System
DHQ	District Headquarter Hospital
DLI	Disbursement Linked Indicators
DOH	Department of Health
DRAP	Drug Regulatory Authority Pakistan
DSS	Disease Surveillance System
EPI	Expanded Programme on Immunisation
EVA	Empowerment, Voice and Accountability for Better Health and Nutrition
FMC	Financial Management Cell
FMU	Financial Management Unit
FY	Financial Year
GDP	Gross Domestic Product
GoKP	Government of Khyber Pakhtunkhwa
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
HPA	Health Professional Allowance
HPAC	Health Policy Advisory Council
HMC	Health Management Committee
HR	Human Resources
HRH	Human Resources for Health
HRMIS	Human Resources Management Information System
HSRU	Health Sector Reform Unit
HTA	Health Technology Assessment
IDSRS	Integrated Disease Surveillance and Response
IHP	Integrated Health Programme
IMNCI	Integrated Management of Neonatal and Childhood Illnesses
IMR	Infant Mortality Rate
IMU	Independent Monitoring Unit
IT	Information technology
KPHS	Khyber Pakhtunkhwa Health Survey
KMU	Khyber Medical University
LHS	Lady Health Supervisor

LHV	Lady Health Worker
LHW	Lady Health Worker
M&E	Monitoring & Evaluation
MAM	Moderate Acute Malnutrition
MCH	Maternal Child Health
MD	Doctor of Medicine
MDGs	Millennium Development Goals
M&E	Monitoring and Evaluation
MHSDP	Minimum Health Service Delivery Package
MHPSS	Mental Health and Psychosocial Support Services
MICS	Multiple Indicator Cluster Survey
MLC	Medico Legal Case
MMR	Maternal Mortality Ratio
MNCH	Maternal, Neonatal and Child Health
MoNHSRC	Ministry of National Health Services Regulation& Coordination
MS	Master of Surgery
MTBF	Medium Term Budgetary Framework
MTIs	Medical Teaching Institutions
NCDs	Non-Communicable Diseases
NHA	National Health Accounts
NHV	National Health Vision
OBB	Output based budgeting
OOP	Out of Pocket Expenditure
OPD	Outpatient Department
ORS	Oral Rehydration Solution
P&DD	Planning & Development Department
PC-1	Planning Commission Performa-1
PDHS	Pakistan Demographic & Health Survey
PHC	Primary Health Care
PHSA	Provincial Health Services Academy
PKR	Pakistani Rupees
PMDC	Pakistan Medical & Dental Council
PPHI	People's Primary Healthcare Initiative
PPP	Public Private Partnership
PWD	Population Welfare Department
RHC	Rural Health Centre
SAM	Severe Acute Malnutrition
SBA	Skilled Birth Attendant
SDGs	Sustainable Development Goals
SHPI	Social Health Protection Initiative
SOPs	Standard Operating Procedures
TB	Tuberculosis
THE	Total Health Expenditure
THQ	Tehsil Headquarter
TRF+	Technical Resource Facility Plus
UHC	Universal Health Coverage
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WB	World Bank
WHO	World Health Organisation

MESSAGE FROM MINISTER HEALTH

Optimal health is key to sustainable wellbeing, development and prosperity of a nation. Government of Khyber Pakhtunkhwa, being cognizant of this fact, is giving top priority to provision of effective, accessible, quality assured and equitable health care in the province. Within weeks of its inception, the current government took initiatives to reform the health department to improve its critical role in ensuring improving health and wellness of people of Khyber Pakhtunkhwa. The most important initiative is embarking on setting the direction of the efforts of all actors working in health sector through developing the first ever provincial level health policy. This health policy was developed through a consultative approach.



Department of Health constituted a Health Policy Advisory Council (HPAC) comprising health representatives of international donors, UN Agencies, Public and Private Health Sectors for provision of advice and technical backstopping for devising a comprehensive health policy. A series of consultative workshops were also organised to get input from provincial stakeholders and health experts. The primary aim of this policy is to reform health systems in all dimensions of health services organisation including prevention of diseases, promotion of good health, delivery of effective curative services through addressing issues in healthcare financing, developing human resource, access to medical technologies and supplies, improving health information and knowledge base for evidence-based decision making, strengthening regulation and governance.

I am confident that this policy will act as a guiding light towards defining priorities and devising concrete action plans to address the health and healthcare related issues in Khyber Pakhtunkhwa, making focussed efforts to achieve the targets set under the Sustainable Development Goals, National Health Vision and Pakistan's international commitments.

I appreciate and acknowledge the efforts of officials of health department, HPAC and all professionals who contributed in development of this policy. I am also thankful to DFID for providing technical assistance through TRF+.


HISHAM INAMULLAH KHAN

SECRETARY HEALTH KHYBER PAKHTUNKHWA

Khyber Pakhtunkhwa Health Policy (2018-2025) is a remarkable milestone achieved by the Department of Health. The commitment and guidance of honourable Health Minister made its development and approval by the Cabinet possible in a short span of time.



This provincial Health Policy has been developed taking into account health and healthcare delivery related current and emerging issues, challenges and needs in Khyber Pakhtunkhwa, achieving SDGs and fulfilling international commitments. This policy will not only act as a guiding framework for the Department of Health and other healthcare providers to develop actionable plans for improving effectiveness, efficiency, quality, accessibility and equity of healthcare services in Khyber Pakhtunkhwa but will also facilitate international donors and partners to align their resources for better health outcomes in the province.

It is envisaged that the strategic plan based upon this policy will lead Department of Health to formulate action plans that will bring improvements in all six building blocks of health system thereby, ultimately, resulting in improvement of health status and quality of life of the people of Khyber Pakhtunkhwa. I must congratulate Health Minister, Health Sector Reform Unit, our international partners, TRF+ and all health professionals who contributed in formulation of the first ever health policy. I also assure that Department of Health will leave no stone unturned to translate the health policy into actions in order to achieve the envisioned outcomes.

A handwritten signature in black ink, which appears to read 'Dr. Farooq Jamil'. The signature is written in a cursive style with a long horizontal line extending to the right.


DR.SYED FAROOQ JAMIL

ACKNOWLEDGEMENT

It was a privilege to have been tasked to lead a team to develop the first ever Health Policy for the Health Sector of Khyber Pakhtunkhwa. The Policy has benefited from the Vision and patronage of Dr. Hisham Inamullah Khan, Health Minister Khyber Pakhtunkhwa who steered the process of formulation and approval of this Policy by the Government of Khyber Pakhtunkhwa. The leadership of Dr. Syed Farooq Jamil, Secretary Health remained unflinching during this entire process of development of Health Policy. Health Sector Reforms Unit (HSRU) of the Department of Health, Khyber Pakhtunkhwa is thankful to Department for International Development (DFID-UK) for providing Technical Assistance (TA) for the development of first ever of Khyber Pakhtunkhwa Health Policy. We gratefully appreciate the outstanding work of Technical Resource Facility Plus (TRF+) (Mr. Farooq Azam, Dr. Muhammad Rahman Khattak and Dr. Abid Hussain). We are thankful to the team of experts of TRF+ particularly Dr. Syed Zulfiqar Ali who did extensive review of the available material, extracted information and drafting the Health Policy.

We are specially thankful to Dr. Asia Asad, Member Provincial Assembly (MPA) of Khyber Pakhtunkhwa for participation in the consultative process. We are also thankful to the members of Health Policy Advisory Council (HPAC) who reviewed the draft policy and shared their technical inputs and aspirations in finalization of the Health Policy.

Health Sector Reforms Unit is also thankful to the technical expert of the Health Department, Khyber Medical University (KMU), Khyber Medical College (KMC), Khyber College of Dentistry (KCD), Provincial Health Services Academy (PHSA), Representatives of Doctors, Nurses and Paramedical Associations of the Khyber Pakhtunkhwa, for their extensive inputs during the long consultation workshops held in the process of formulation of this Policy.



DR. SHAHID YUNIS
CHIEF HSRU

1 Background

The Health Department of Khyber Pakhtunkhwa is undertaking a pioneering step in developing a Health Policy at a provincial level. Health Policy is usually developed at the national level. The opportunity has come about because of the evolving health system and governance in Pakistan after the Eighteenth Amendment to the Constitution of Pakistan on April 19, 2010.

1.1 Health Policy in a Federal Form of Government

A 'health policy' in the traditional context denotes an official statement by the highest level of government, usually the Cabinet, which sets the mission, vision, goals and strategies, and in many cases, operational plans to achieve health and health systems outcomes¹.

Despite removal of concurrent responsibility shared between the federal and provincial governments, the federal government continues to fund programmes and initiatives in provinces (the Prime Minister's National Health Programme is an example). Health policy, therefore, has attained added importance and is both politically sensitive and practically challenging, an area fraught with ongoing demands at all stakeholder levels. Recurring themes in federal-province relations are concerns about funding, and the battle between the central government's desire for cohesive national policies on the one hand and the provinces' desire for greater discretion and flexibility on the other.

Provinces now have the mandate to strategize and plan in the health sector.

It is legitimate to pronounce an overarching national health policy in areas and subjects that should have a national character; The national health policy should now be limited to high-level norms and standards, approved at the level of the Cabinet. All other policy matters stand devolved to the provinces after the 18th Amendment to the Constitution of Pakistan.

1.2 Health Department in KP – Reforming & Transforming

Over an extended period of time and especially over the last five years, Government of Khyber Pakhtunkhwa, has tried to bring changes and reforms in various sectors, including health sector.

The party in power during 2013-18 has been brought into government for another five-year term with a larger majority by the people of the province. This gives them the mandate to continue implementing policy reforms.

¹ Health Policy: An Introduction to Process and Power. Gill Walt. Zed Books 1994

In the health sector, the government plans to resume its work to improve the health status of people as part of its effort to achieve Sustainable Development Goals (SDGs).

The Health Minister is personally leading the efforts for developing vision, policy and plans for the health sector in Khyber Pakhtunkhwa.

The Department of Health of the government of Khyber Pakhtunkhwa has taken measures to implement reforms. Important steps taken as part of the Health Sector Strategy, have focused on:

a. Institutional Development.

Government of KP undertook concrete steps to improve governance in the health sector by reviewing “Rules of Business” and “Organizational Structure” of Health Department in accordance with the stated roles of stewardship, regulation of health service provision and managing innovations in the financing mechanisms for health care provision. Establishment of Board of Governors with maximum authority was an important step in this regard. Major hospitals in the province providing tertiary level care and medical education – Medical Teaching Institutions (MTIs) were provided autonomy by Acts of the Assembly.

b. Provision of health services through adequate human resource, equipment and Supplies.

From 2015 onwards, 90% budgeted positions have been fulfilled. In 2017 all positions of Medical Officers, LHVs, and Medical Technicians at primary health care facilities were filled. The number of Medical Officers increased from 2520 in 2012-2013 to 6531 in 2017-18.²Over 22000 posts were created by the government during 2013-17, out of which 15000 were created in budget 2016-17.

To improve governance and accountability in the public sector, autonomy was granted to eight teaching hospitals in the province. Autonomous and fully empowered boards with members from private sector are in place. District Health Plans were prepared along with provision of budget for all 25 districts to provide Minimum Health Services Delivery Package (MHSDP) under Integrated Health Project. Twenty-three stabilization centres were also established at DHQ hospitals along with provision of nutritional supplements under this project.

c. Free Treatment and Free Medicine to the Marginalized Population.

Under the Chief Minister’s Pro-Poor initiatives, free Medicines worth Rs. 1 billion per year for Accidents & Emergencies Departments of MTIs and DHQs were provided. A programme was launched for providing free treatment of cancer

²Department of Health Yearbook 20167-17.

through which Rs. 1.9 billion were allocated for treatment of more than 5000 cancer patients. Another initiative was providing Cash for Expectant Mothers, Rs 2700 were paid to each expectant mother, in instalments for visiting hospitals for obstetric care.

The government of Khyber Pakhtunkhwa Social Health Protection Initiative (Sehat Sahulat Program) can rightly be termed a flagship programme of KP Government. It is the most ambitious initiative in Pakistan that caters to a vast majority of underprivileged population and is a step towards Universal Health Coverage. Under this scheme government of KP paid health insurance premiums for 69% of the entire population of the province.

Keeping in view the importance of investment in health for economic development, the Government of Khyber Pakhtunkhwa increased the budget of health sector from PKR 30.3 billion in 2012-13 to PKR 66.49 billion in 2017-2018.

Khyber Pakhtunkhwa has suffered major losses due to natural as well as manmade calamities at regular intervals over the last decade which affects its progress in health sector, as in other aspects.

1.3 The Khyber Pakhtunkhwa Health Roadmap

The Khyber Pakhtunkhwa Health Roadmap is an initiative of the government of Khyber Pakhtunkhwa using innovative and targeted interventions in high priority areas of health care. The Roadmap in Khyber Pakhtunkhwa is helping the Department of Health to ensure that: i) critical frontline staff and medicines are available in primary health care facilities, ii) children receive routine immunization; iii) reliable and essential data is regularly available and iv) routines to drive progress are established. The Minister of Health reviews progress in these areas with support from the Independent Monitoring Unit (IMU), TRF+ and Roadmap team in stock take meetings held every two months, attended by DFID, and officials from Health, Planning and Development, and Finance Departments.

1.4 Six Core Health Goals – World Health Report 1999

The World Health Organization, in its World Health Report 1999, set out a list of six core health goals: improving the health status of the population; reducing health inequalities; enhancing responsiveness to legitimate expectations; increasing efficiency of the health-care delivery systems; protecting individuals, families, and communities from significant financial loss as a result of health problems; and enhancing fairness in the financing and delivery of health care.

1.5 Process for Developing Health Policy in Khyber Pakhtunkhwa

The health policy was prepared in view of the key issues/problems related to health status of the population, health system operations, intersectoral coordination for population health improvement, priorities of current government in health sector, achieving health related SDGs and Universal Health Coverage, national priorities in health sector (as envisaged in National Health Vision 2016-25.), and international/regional commitments. etc. A separate Situation Analysis Report details the current situation, and issues and challenges in health sector in Khyber Pakhtunkhwa.

2 Challenges Faced in Health Sector in Khyber Pakhtunkhwa

Review of data and information collected for the Situation Analysis brings to light the challenges for the health sector in Khyber Pakhtunkhwa. Key challenges are given in the following sections.

2.1 Governance, Management & Accountability

As a result of the 18th Constitutional Amendment, the “Concurrent List” of responsibilities of provincial and federal governments was abolished and authority was devolved. The Ministry of Health was abolished and Federal Government assigned some health-related functions, responsibilities/institutions to different government ministries/divisions at the federal level. In order to fulfil some functions at the federal level, Ministry of National Regulations and Services was established in April, 2012. Later on, the scope of work of the ministry was expanded and its nomenclature was also changed to Ministry of National Health Services, Regulations and Coordination. However, the federal government has been gradually expanding its role, and has initiated implementation of a large National Health Program. This has led to duplication and in some cases conflict between the federal and provincial governments.

While the government of Khyber Pakhtunkhwa undertook several important steps to improve governance, management and accountability in the health sector, with significant improvements Tertiary Care, for example; associated challenges of transition, integration, implementation, organizational capacity building and adjustment remain at different levels. These much-needed reforms like establishment of Boards of Governors in MTIs, Health Care Commission, Health Foundation etc. are still at early stages of development and will require continued bolstering and support. Key governance initiatives also involve district decentralization and attempts at improving monitoring and accountability of public sector delivery. Lack of clarity regarding roles of Department of Health related to stewardship are yet to be clearly set out.

The Government of KP has further decentralized health functions to the district level as part of the larger Local Government Act 2013. District Councils and Nazims are supposed to now have planning and financial authority for public sector health facilities. However, issues remain as the Department of Health is responsible for some key functions like administrative control to ensure staff presence and performance, delivery of quality care and functioning of outreach preventive care.

In addition, managerial capacities and systems are weak at the district level. Firstly, there is lack of division of supervisory responsibilities between the DHOs and the provincial Department of Health. Secondly, systems and skills for financial management are absent at the district level and even existing district generated data on patient volume and stock presence is not used for evidence-based supplies forecasting. Thirdly, supervision of facilities by district managers highly varies across individual district managers in terms of number of facilities visited as well as type of supervision provided. Thus, supervision remains a major weak area of the Department of Health. Though supervisory visits are an essential element of a supervisory mechanism, cost and logistics associated with travelling to visit different health facilities in KP is inadequate. There is shortage of vehicles for all the supervisory staff and even when vehicles are present, few are in working order, or there is no money to buy fuel.

Formation of Health Management Committees is another major step by the DOH in KP. Health Management Committees have been constituted through an administrative order of the Government of Khyber Pakhtunkhwa to oversee health care delivery at the District Hospital level. While the committees have been notified, very few are functional.

Notification for merger of erstwhile FATA with Khyber Pakhtunkhwa (KP) province was issued in June 2018. Following the notification, Khyber Pakhtunkhwa government has merged the directorate of health services of newly merged districts into the provincial health department. as a result, the Director Health of these districts would report to the provincial health secretary. As part of the merger, the administrative units of KP would change as a result of the drawing of new districts and subdivisions. Currently, there are 26 districts in KP. According to officials, initially the 7 tribal agencies could be converted into new districts of KP. However, the boundaries may be redrawn in the future, in part because the administration of newly merged districts is already heavily dependent on the KP government: currently, about fifty-two thousand employees of the KP government work in departments of newly merged districts. Officials say that in some crucial sectors, such as education and health care, synchronization will not be easy if the newly merged districts are not brought into parity with other districts of KP³.

³Imtiaz Ali Mainstreaming Pakistan's Federally Administered Tribal Areas Reform Initiatives and Roadblocks United States Institute of Peace www.usip.org Special Report

2.2 Quality of Health Services

Another major weakness is the lack of focus on quality of services provided in public health facilities. The introduction of quality of health care services in health facilities is a gradual and incremental process requiring both organizational and behaviour change on the part of managers, supervisors, and health facility staff. The state of most health centres in the province, especially BHUs and RHCs make provision of quality health care services difficult. The design, construction and condition of the health facilities do not facilitate quality of care, especially infection control. In addition, waste disposal system is very weak in most of the health centres. Most health centres do not have a steady water supply, electricity supply or a functional sewerage system. Staff in the health centres lack proper training for provision of quality health services.

Under the Improving Quality of Healthcare Services Project, Khyber Pakhtunkhwa Department of Health, tools were developed for assessment of quality of care in health centres. These tools are quite detailed requiring a long time to complete assessment of the health centres for quality of services. In some districts, staff was trained on implementing measures that would enable them to meet quality standards. Under the project, in selected districts, these tools were used by trained staff in self-assessment. However, these tools are not being used widely.

2.3 Regulation of Health Providers

Regulation of the health sector, both private and public is still weak. The KP Healthcare Commission was established in 2015. However, there are issues related to the capacity and resources availability with the Healthcare Commission to perform its role. It is still primarily involved with only registration of the health care providers with no capability to perform quality assessments.

The Drug Control Administration inspects facilities involved in production, distribution and sale and dispensing of medicines to ensure adherence to relevant regulations regarding drug price controls. However, it does not have sufficient monitoring capacity⁴. Drugs are not being registered by their generic names as required in by the Drugs Act. Moreover, Drug Rules for Khyber Pakhtunkhwa were last developed in 1982 and except for minor amendments. they have not been revised. Also, there is no legislation for ayurvedic or herbal

⁴ The Network Consumer Protection 'Prices, Availability and Affordability of Medicines in Pakistan' August 2006

products (not defined as drugs). Furthermore, there is no standardization for the manufacturing and sales of products, provided by alternative health care providers. Lastly, the quality control laboratories do not yet meet WHO standards.

2.4 Human Resources

Pakistan has a low density of essential /skilled health professional (physicians including specialists, nurses, lady health visitors (LHVs) and midwives) - density of 1.45 per 1,000 population⁵ against WHO's recommended minimum of 4.45 per 1,000 population⁶ necessary to achieve universal health coverage. In KP, Essential Health Workforce density is 1.15 per 1,000 population. These numbers include public and private sector personnel. However, initiatives for both HR production and deployment has been traditionally tilted towards doctors. Physician density still remains higher than that of nurses, midwives and LHVs. There is also a low pharmacist to population ratio. Other pressing issues in Human Resources for Health include poor distribution of HR, retention issues and low work-place satisfaction levels. This results in significant brain drain at all levels.

Based on the WHO recommended global ratio, the gap for physicians and specialists in KP including the newly merged districts is estimated at 18,824, while the gap for nurses and midwives is estimated at 141,792.

Moreover, reduction in high attrition rate is a major challenge. Enhancing job satisfaction among the Human Resources in health poses another major challenge. KP also faces issues in terms of equitable deployment of staff across districts. There are 12 districts that have less than 75% of the required doctors; discrepancies noted between the data reported by IMU shows lesser number of postings and those shown by DHIS show higher number of postings⁷.

While job descriptions have been developed and are available at the DGHS office, these have not been provided to the districts and health centres. Most staff are not aware of their duties, working hours, responsibilities and reporting lines. Furthermore, professional education in health is run at sub-optimal level without synchronizing the curriculum with modern pedagogical techniques, international standards and the local requirements. In addition, licensing and

⁵ WHO, 2017; World Health Statistics: Monitoring health for the Sustainable Development Goals

⁶ WHO, 2016; Global strategy on human resources for health workforce 2030

⁷ Health System Assessment of KP & Punjab

renewal of licensing of health practitioners is weak, and is not linked with improved qualification, competence, performance and continuous professional development. There are weak institutional measures to assess the performance of health staff.

Lady Health Workers Programme has been a success in Pakistan and in KP. However, it could pose a challenge in view of the government initiative to introduce Integration of Health Services Delivery with Special Focus on MNCH, LHW, EPI & Nutrition Programs through the Integrated Health Project. Another important consideration is the 'regularisation' of LHWs' Programme cadres as government/public servants. This has led to a large increase in the cost of the program and cost per LHW per year. Programmes such as the MNCH, LHW programme, EPI have programme specific job descriptions and reporting lines, however, these have become ambiguous after launch of the Integrated Health Programme.

2.5 Health Financing

In KP, as per National Health Accounts estimates Out of Pocket (OOP) expenditure dominates health spending with 67% in 2015-16, followed by 21% that is financed from the public sector⁸.

There are inefficiencies in the public health spending due to weak management systems, resulting in low utilization and eventual lapse of funds. Payments are not linked to performance. Moreover, the districts' recurrent health budget is largely consumed in salaries due to an increase in staff salaries over the years. Furthermore, donor funding has been minimal (<2% of total health expenditure). The donor funding could be better aligned and coordinated with governments' strategies.

Many population sub-groups lack financial protection, and face risk of catastrophic health expenditure.

2.5.1 High out-of-pocket expenditure for Health

National Health Accounts 2015-16 estimate the proportion of OOP health expenditure constituted in total health spending is 67%. Another household survey found that Khyber Pakhtunkhwa's share of out-of-pocket expenditure for health care (76.6%) is the highest of all provinces. Punjab is the second highest, whereas Sindh is third and Baluchistan is the lowest in terms of OOP

⁸ National Health Accounts Report 2015-16, published in 2018

health expenditures share out of household incomes. A household in KP province spends almost three times higher as compared to Baluchistan. If comparison is drawn of the OOP health expenditures across provinces for persons below and above poverty line, then it appears that KP households have been spending more than all other provinces whether in rural or urban areas. One of the reasons could be low government spending in the health sector for KP. Secondly this may also identify that the incidence of catastrophic health expenditures is more in KP province⁹.

2.6 High Prevalence of Communicable Diseases

Communicable diseases are still the most important health problems in Pakistan and in KP. Common causes of death and illness are acute respiratory tract infections, diarrhoeal diseases, malaria, tuberculosis and vaccine preventable infections. Over the last 3 years, there have been outbreaks of dengue fever in the province due to which more than one hundred lives were lost, while hundreds were infected. In young children, diarrhoea and respiratory illness remain as the major killers¹⁰. Maternal deaths due to preventable causes like sepsis, haemorrhage and hypertensive crises are also common. Pakistan is one of the three remaining countries where Polio is still endemic¹¹. Moreover, Pakistan has an endemicity of hepatitis B and C in the general population with 7.6% affected individuals. Furthermore, it has the fifth highest tuberculosis burden in the world and has a focal geographical area of malaria endemicity¹², and an established HIV concentration among high risk groups¹³. Communicable diseases, maternal health issues and under-nutrition dominate and constitute about half of the Burden of Disease¹⁴.

2.7 Increasing Morbidity and Mortality due to Non-Communicable Diseases (NCDs)

Non-communicable diseases, including cardiovascular diseases, cancers, respiratory diseases, diabetes, and mental disorders, and injuries have become

⁹Households Study on Out-Of-Pocket Health Expenditures in Pakistan: Mahmood Khalid and Abdul Sattar Forman *Journal of Economic Studies* Vol. 12, 2016 (January–December) pp. 75-88

¹⁰UNICEF. Child Survival: Under-Five Mortality. 2016. <http://data.unicef.org/child-mortality/under-five.html>

¹¹Polio Global Eradication Initiative. <http://www.polioeradication.org/Keycountries.aspx>

¹²Global Fund. Pakistan 2014 Malaria Grant Concept Note. Islamabad: 2014.

¹³UNAIDS. Global AIDS Response Progress Report. Geneva: 2014.

¹⁴World Health Organization. Country Cooperation Strategy for WHO and Pakistan 2011–2017. Eastern Mediterranean Regional Office. Cairo: 2013.

the major causes of morbidity and mortality in KP. Tobacco use and hypertension are the leading attributable risk factors for deaths due to cardiovascular diseases, cancers, and respiratory diseases. Pakistan has the sixth highest number of people in the world with diabetes; every fourth adult is overweight or obese; cigarettes are cheap; anti-smoking and road safety laws are poorly enforced; and a mixed public–private health-care system provides suboptimum care. Furthermore, almost three decades of exposure to socio-political instability, economic uncertainty, violence, regional conflict, and dislocation have contributed to a high prevalence of mental health disorders¹⁵. Projection models based on the Global Burden of Disease 2010 data suggest that there will be about 3.87 million premature deaths by 2025 from cardiovascular diseases, cancers, and chronic respiratory diseases in people aged 30–69 years in Pakistan, with serious economic consequences.

Estimates indicate that there are one million severely mentally ill and over 10 million individuals with neurotic mental illnesses within the country. Non-communicable diseases and poverty are interlinked and increasing poverty may lead to higher prevalence of non-communicable diseases. The common underlying factors for non-communicable diseases including lifestyle, nutrition and smoking have not been addressed adequately.

Pakistan lags far behind in the attainment of global NCD targets. According to WHO, the country has not devised any evidence-based national standards for the management of major NCDs through a primary care approach¹⁶. The country's NCD mortality data is of poor quality, and there is no risk factor surveillance. Only scant morbidity data are available as there are no systematic clinic- or hospital-based registries of public and private health facilities.

Also, Pakistan has no population-based cancer registry maintained on a national basis. Khyber Pakhtunkhwa does not have an action plan to reduce physical inactivity and unhealthy diet, the main reasons behind the rise of NCDs. Seen as a particular threat to Pakistan, it is estimated that by 2020, two out of three people in the country will suffer from NCDs. Same effects could be expected in KP.

¹⁵ [Jafar TH](#) et al 'Non-communicable diseases and injuries in Pakistan: strategic priorities' *Lancet* 2013 Jun 29 ;381(9885):2281-90.

¹⁶ Non-communicable diseases and injuries in Pakistan: strategic priorities. Series Health Transitions in Pakistan. *Lancet* Volume 381, Issue 9885, P2281-2290, JUNE 29, 2013

In addition, the primary care level is not well programmed to deliver preventive or treatment services for NCDs. Public sector health centres lack core elements and capacity to manage integrated NCD programs. Population-based prevention is not addressed.

2.8 Malnutrition

Pakistan has one of the highest prevalence of under-weight children in South Asia. Similarly, stunting, micronutrient deficiencies and low birth weight babies contribute to an already high level of mortality in mothers and children. In KP, although the entire population is at risk of malnutrition, children under the age of five and pregnant and lactating women are the most vulnerable. The Multiple Indicator Cluster Survey (MICS) 2017, show that prevalence of moderate underweight children in Khyber Pakhtunkhwa is 20.8% and 7.5% children are severely underweight. Prevalence of moderate and severe stunting in the province is 41.4%, 20.7% of children being severely stunted. Moderate and severe wasting amongst children is 8.0%, while 3.0% are severely wasted. In the province, 6.8% children are overweight.

2.9 Issues in Maternal, Neonatal & Child Health

With a neonatal mortality rate exceeding 45 per 1,000 live births, a UNICEF report ranked Pakistan as the riskiest place to be born on earth¹⁷. Although the recent Demographic and Health Survey 2017-2018 indicates that the situation has improved, the neonatal mortality rate in Pakistan is among the highest in the world.¹⁸ Other health indicators, particularly those pertaining to maternal and child health and nutrition, are worse than other countries in the region with comparable or lower socioeconomic indicators.¹⁹ Around half of the mothers practice exclusive breastfeeding in the province. Leading causes of death in children under-5 years are preterm birth complications, pneumonia, birth asphyxia, diarrhoea and malaria.²⁰ Yet, there are few programmes and minimal investments in addressing these causes of mortality and morbidity. Though

¹⁷ UNICEF. Every child alive: the urgent need to end new-born deaths. New York: United Nations Children Fund, 2018. Government of Pakistan. Pakistan Millennium Development Goals report 2013. Islamabad: Planning Commission, Government of Pakistan, 2013.

¹⁸National Institute of Pakistan Studies. Pakistan Demographic and Health Survey: key indicators report, 2017–18. Islamabad: National Institute of Pakistan Studies, 2017.

¹⁹Akseer N, Kamali M, Arifeen SE, et al. Progress in maternal and child health: how has South Asia fared? *BMJ* 2017; 357: j1608.

²⁰<http://www.who.int/news-room/fact-sheets/detail/children-reducing-mortality>

skilled birth attendance (SBA) has improved from 18% in late 1990s' to 72.2% in 2017²¹, there is still room for improvement.

2.10 Low Immunization Status

While the DOH lays strong emphasis on its immunisation programme, vaccination coverage is low. The KP Health Survey 2017 shows that 41.7% of children aged 12 to 23 months were fully immunised by 12 months of age. It is important to note that 17.3% of children aged 0-23 months did not receive any vaccination at all.²²

2.11 Weak Referral System

Despite a major increase in health budget and reforms across the board in health care system, the referral system is still weak. This poor referral system leads to underutilization of primary healthcare and places enormous burden on tertiary care facilities. This situation leads to higher unit costs adversely affecting the quality of care and also distracts tertiary care institutions from their primary goal to become centres of excellence in quality health education and research.

2.12 Disabilities

Disability due to various causes is high while services for the disabled population are limited, including provision of assist devices to improve their quality of life. The PDHS 2017 findings suggest that the proportion who have a lot of difficulty or cannot function at all in at least one functional domain ranges from 2% to 9% among those age 5-49 and then increases to 14% among those age 50-59 and 32% among those age 60 or above.

2.13 High Population Growth Rate & Low Contraceptive Use

The province of Khyber Pakhtunkhwa (including newly merged districts) with 12.8 % area of Pakistan is occupied by 17.1% of country's population. According to the sixth Population and Housing Census 2017, KP's population stands at 35.5 million. Its population has grown with an inter-censual (1998, 2017) annual growth rate of 2.82%. The urban population in KP has slightly increased to 17.67% of the provincial population. There were 17.5 million women in the province – 49.3% of the provincial population. According to

²¹KP Health Survey 2017

²² ibid

current growth rates, the population is projected to increase to 51 million by 2030. High population growth rate was led by a continuously high birth rate and rapidly declining mortality rate.

The BoD is rendered worse by an increasing population, with Pakistan now the sixth most populous country in the world. Decline in population growth rate has been slow, while contraceptive prevalence of only 31%²³ is far less than other regional countries. Unmet need for birth spacing is around 21%²⁴, and the health system has to strategize to address this gap. In the newly merged districts, the situation is even more alarming.

2.14 Access to Health Services and Inequities

Khyber Pakhtunkhwa has seen progress in access to health care services; however, the gains are uneven across different service areas. Access to, and affordability of, essential medicines is low. Moreover, there are geographical disparities in coverage between districts and rural-urban area. Evidence shows that low income groups are likely to have lower levels of health, nutrition, immunization and family planning coverage. Some of the districts in Khyber Pakhtunkhwa have few health service providers and health facilities. Kohistan, Tank, Torghar are some examples of districts where people have most difficulties in accessing the health services. Also, given the distance and limited human resources for health and nutrition in poorer and remote populations, the primary care system is the only effective way to reduce geographical disparities in Pakistan²⁵. Clearly, there is a need to invigorate Basic Health Units and the Lady Health Worker programme. This approach in no way undermines the need to invest in hospital care.²⁶

As a result of technological development in the field of diagnostics, increasingly, diagnosis of diseases is becoming technology dependant. Availability of diagnostic equipment and trained staff is a major issue in the province in general and more so in the public-sector health facilities. Department of Health KP allocated PKR 3 billion to equip health facilities with state of the art medical, surgical and diagnostic equipment during the previous year, however there are still major gaps in this area.

²³PDHS 2017-18

²⁴ ibid

²⁵Bhutta ZA, Hafeez A, Rizvi A, et al. Maternal, new-born, and child health in Pakistan: challenges and opportunities. *Lancet* 2013; 381: 2207–18.

²⁶www.thelancet.com Vol 392 October 20, 2018 page 1376

A National Essential Drugs List exists, but the stock and availability of the drugs are problematic. The list contains 452 drugs (the largest in South Asia), including anti-hypertensive, lipid lowering, and anti-diabetic drugs, as well as bronchodilators and anti-depressants. However, only a quarter of primary health centres are stocked with basic medicines such as aspirin and many lack bronchodilators²⁷.

In KP, there has been progress in availability of critical medicines at BHUs at 68% in the current year, with similar figures for RHCs. This is largely driven by Roadmap stock takes. At the same time, there is wide variation by districts with at least 7 districts reporting less than two-thirds availability of medicines²⁸.

2.15 Health Systems

Khyber Pakhtunkhwa has a healthcare delivery mechanism with multiple players, which includes government funded facilities, para-statal health system, private sector, civil society and philanthropic contributors. A major strength of the government's health care system in Pakistan is an outreach primary health care, delivered at the community level by Lady Health Workers (LHWs) and an increasing number of community midwives (CMWs) who have earned success and trust in the communities. Complementary, alternative and traditional system of healing is also quite popular in the province. There are many different categories of non-allopathic service providers who deal with patients in a wide variety of settings and are unregulated. There are more than 50,000 Hakims/Tabibs and 450 Vaidis registered with National Council for Tibb as Medical Practitioners (Tabibs/Vaidis). Registration is limited to those providers who have certificates from the National Council of Tibb and the National Council of Homeopathy.

The health system faces challenges of vertical service delivery structures and low performance accountability within the government, creating efficiency and quality issues. There is also duplication of services by the private sector. Although having the potential, the private sector contributes least towards preventive and promotive health services. The public sector is inadequately staffed and job satisfaction and the work environment need improvement. The overall health system also faces an imbalance in the number, skill mix and

²⁷ NCDs Policy Brief - Pakistan February 2011 The World Bank, South Asia Human Development, Health, Nutrition, and Population

²⁸ Health Systems Assessment of Punjab & KP.

deployment of health workforce, and inadequate resource allocation across different levels of health care i.e. primary, secondary and tertiary. In order to produce quality workforce for the health sector, the quality of medical and allied education both in public and private sector needs to be looked into.

2.16 Security Issues, Violence & Disasters

Khyber Pakhtunkhwa faces numerous challenges because of its geography leading to social, economic, political and cross border challenges compounded by successive natural catastrophes. Khyber Pakhtunkhwa has a long and porous border with Afghanistan which is undergoing a prolonged period of insurgency. Due to this and the continuing war on terror in newly merged districts, this has adversely impacted all sectors, especially health sector.

KP and the newly merged districts have the highest incidences of death due to violence, primarily owing to the fallout of war on terrorism and insurgencies. The overall uncertainty arising due to this adverse situation has dampened the economic activity in KP²⁹. The interplay between natural disasters and conflict shocks can have more severe consequences compared to when these shocks occur independently³⁰. Militants have attacked facilities and carried out vandalism (theft of expensive equipment), killings, and kidnappings of health personnel. The frequent and continuous emergencies/crises faced by the province severely impacted health care provision. Provision of health services was also hampered by the lack of qualified personnel, vacant posts, and high levels of absenteeism³¹.

2.17 Climate Change

Climate change is expected to exacerbate health problems that already pose a major risk to vulnerable populations. With increase in temperatures and frequency of natural disasters, disease prevalence is likely to rise particularly of water-borne illnesses (like dengue) and diseases vectors including diarrhoea³². Heat strokes, gastrointestinal problems, respiratory diseases, skin diseases, eye infections, malaria and mortality due to extreme weather events are likely to

²⁹ Economic Growth Strategy – Reclaiming Prosperity in Khyber-Pakhtunkhwa. P&DD Khyber Pakhtunkhwa

³⁰ McPake, et al. (2015)

³¹ The World Bank. 2016. "IDA18 – Special Theme: Fragility, Conflict, and Violence". Washington, DC. USA

³² Intergovernmental Panel on Climate Change (IPCC) Assessment Report 5 (AR5) 2014

increase in severity, frequency and intensity. Storms, floods and droughts, caused by climate change, can force people to migrate to urban centres of the province. This can have spill-over effects such as lack of housing facilities, water and sanitation problems and an increase in transfer of diseases in high population density areas of KP. KP already suffers from high mortality rates for infants, children and women, and inadequacy of public health facilities and service, which are likely to be exacerbated by the impacts of climate change if not addressed effectively.

Climate change has the potential to increase risk for non-communicable diseases, in particular respiratory diseases and some types of cancer.

3 Khyber Pakhtunkhwa Health Policy – Vision, Mission, Outcomes 2018 - 2025

3.1 Vision

Accessible, equitable and quality healthcare for all people of Khyber Pakhtunkhwa to advance our community's well-being, productivity and prosperity.

3.2 Mission

To develop and implement a sustainable, coordinated, integrated and comprehensive health system at all levels, based on the Primary Health Care approach through the District Health System, to ensure universal access to quality health care.

3.3 Principles

Health policy implementation in Khyber Pakhtunkhwa will be driven by the following key principles:

- I. The Health Department will ensure universal health coverage for the people of Khyber Pakhtunkhwa based on following principles:
 - Universal
 - Equitable
 - Accountable
 - Results based management
 - Community oversight & involvement
 - Quality of care
 - Community focused
 - Safe for patients and staff
 - Innovative
 - Responsive
 - Transparent
 - Sound management & governance
- II. To be achieved as part of overall government commitment to achieving Sustainable Development Goals (SDGs) and “Health in All Policies”.

3.4 Outcomes

The Department of Health Khyber Pakhtunkhwa will realise its vision and achieve its Mission by aiming to bring about a set of Outcomes in partnership with stakeholders and partners.

The Minister of Health, after taking office, had a meeting with staff of the Department of Health and shared his views on the health sector in KP. His opening remarks can be adopted as a Mission Statement for the Department of Health in Khyber Pakhtunkhwa. “To introduce and implement policies that would reform and strengthen the Khyber Pakhtunkhwa (KP) Province’s Healthcare System, enabling it to provide essential, cost effective, quality, equitable, universal and sustainable health care to all its citizens and with focus on developing Preventive, Primary & Secondary Healthcare and strengthening Tertiary level healthcare.”

The Policy Outcomes have been chosen as these are reflected in the Outputs Based Budget for three years 2018 – 2021.

1. Enhanced coverage and access of essential health services especially for the poor and vulnerable
2. Measurable reduction in the burden of disease especially among vulnerable segments of the population
3. Improved human resource management
4. Improved governance, regulation and accountability
5. Enhanced health financing for efficient service delivery & financial risk protection for people of KP

4 Health Policy Outcomes and Policy Actions

4.1 Enhanced Coverage and Access of Essential Health Services for all Especially for the Poor and Vulnerable

1. Government of KP will improve the coverage of primary, preventive and promotive health services, through the execution of Minimum Health Service Delivery Package at all primary and secondary health facilities in the province. New-born survival; birth spacing and contraceptives supply; communicable and non-communicable diseases; mental health; under-nutrition; disabilities; problems of ageing population will be areas of special focus.
2. Quality of services will be ensured by implementing Primary and Secondary Healthcare Standards for delivery of service.
3. Primary Health Care (PHC) approach through the District Health System will be implemented in the province with steps for integration of services and ownership of interventions at the local level including training the outreach health workforce (vaccinators, sanitary workers and malaria inspectors etc.) and converting them into multipurpose health care workers, attached to the health facility.
4. The Department of Health will focus on renovation of existing RHCs and THQ hospitals as a priority. Construction of any new public health facilities will be based on exhaustive assessment of need. New public health facilities will only be constructed in areas where there is insufficient capacity in both the private and the public sector to provide basic health services. New hospitals, especially category A hospitals shall not be constructed in the centre of cities rather near exit/entry points for ease in accessing especially in case of emergency or disasters
5. Availability of staff (especially female staff) for service delivery particularly in primary health care facilities in rural areas will be ensured by exploring differential packages of salaries and performance incentives.
6. A system of supportive supervision will be revitalized.
7. Integrated delivery of PHC services will be strengthened. Outreach workers (vaccinators, sanitary workers and malaria inspectors etc.) will be trained and converted into multipurpose health care workers, attached to the health facility.

8. All health facilities in every district will be attached with a teaching institution in the district and/or specialists (initially Gynae/obstetrician, paediatrician, surgical and medical specialist) working in tertiary and district headquarter hospitals will have periodical visits to remote health facilities with publicized schedule. Staff of district level will receive continuing medical education at these teaching institutions.
9. The Health Department in collaboration with Khyber Medical University and PHSA will develop training curriculum for improving skills of medical officers as effective General Practitioners. Through medical training institutions, Family Medicine as a diploma &/or Fellowship level post graduate training will be made available on a large scale.
10. Productive community involvement at the health facility level will be strengthened to improve responsiveness.
11. Referral Mechanism will be strengthened and made functional to reduce visits for conditions that could be managed at primary and secondary level of care.
12. The Department of Health will specially focus on provision of Family planning services through the health facilities network and community-based Lady Health Workers and Community Midwives.
13. The Department of Health will make joint efforts with Population Welfare Department for enhancing family planning.
14. Adolescent and Youth Health Strategy will be developed to enable this important segment of the society to grow healthy and contribute to development of the province and the country.
15. Innovative management models for health facilities at all levels will be developed and implemented to enhance coverage and reduce costs.
16. Private sector would be engaged as a partner in healthcare delivery through appropriate mechanisms for meeting national SDG targets including reporting on key indicators.
17. Develop policies and guidelines for 'purchase' of services from the private sector by the government in areas where high quality private sector service providers are available. In all such arrangements provision for safety nets for the poor would be an essential element.
18. Autonomy to hospitals providing tertiary level health care will be strengthened under the Medical Teachings Institutions (MTI) Act.
19. Divide province into Medical Regions based on population and health care services availability. Introduce, fully equip and provide at least one major specialty centre like Gynaecology, Cardiology,

Emergency/Trauma/Burn care facility and Dialysis centre in every region.

20. All category A and B hospitals will allocate at least 10% of beds to Intensive Care Unit.
21. All health facilities will be on solar/renewable energy.
22. Innovative strategies will be implemented to ensure availability of primary health care services and at least four specialty areas (gynaecology/obstetrics, general medical, general surgery and paediatrics) in the four districts with lowest level of availability of services (Kohistan, Torghar, Tank, North & South Waziristan).
23. Government of KP will facilitate universal access to timely and high-quality emergency care (curative and rehabilitative) that mitigates the effects of injuries and violence in addition to continuing provision of free emergency drugs.
24. Physical and psychosocial rehabilitation services will be strengthened to address long-term effects of violence and injuries.
25. Address the health effects of emergencies, disasters, crises, and conflicts, and will take steps to mitigate their social and economic impacts. Entire health care system will be made resilient to disasters (climate change, natural disasters, disease outbreak etc.) in terms of both disaster mitigation response and continued provision of services during acute crisis / emergencies.
26. Promote strategies to address public health aspects of road safety.
27. Facilities for disabled will be enhanced through new initiatives and enhanced support to the Paraplegic Centre and the services at all district headquarters level.
28. Accident and emergency response centres with defined Standard Operating Procedures (SOP) shall be developed. A three-tier trauma management system shall be introduced in Khyber Pakhtunkhwa with hospitals classified as 'local trauma centres' similar to US level III, 'divisional trauma centres' similar to US level II, and 'regional trauma centres' similar to US level I. All hospitals with trauma care facilities (public as well as private) shall be categorized into one group of the three levels of trauma care. The transportation time of a most seriously injured patient to a level I or level II centre should not exceed 30 minutes. If this is not possible, the patient shall be stabilized in a level III centre and then be transferred to a level II or level I trauma centre. Rescue 1122 sub-centres will be established at all DHQ hospitals. These centres will have linkages with Rescue 1122, for the provision of pre-hospital care services.

29. Ambulance Service will be established for maternal and child care. Utilization of existing ambulance services will be reviewed and improved. Provision of other transportation options will be explored to make access to health care easy for the disadvantaged.
30. Burn care facilities shall be established at the divisional level.
31. Effective infection control measures will be implemented in all public and private sector hospitals, including hospital waste disposal. Waste Management services/Incinerators will be made functional at least at the district level, with arrangements for collection and disposal of waste from BHUs/RHCs in the districts.
32. The Department of Health will provide institutional support to research in areas with policy implications for the system wide reform with respect to health sector. A committee comprising HSRU, PHSA and KMU will identify health policy key areas for research in health sector in KP. Priority will be given to operations research. All programs will reflect a separate budget line with financial allocations for operations research in respective programs.
33. Review in depth health service delivery system in newly merged districts of erstwhile FATA and develop plans for delivery of services in synergy with other areas of KP.

4.2 Programmes to Ensure Measurable Reduction in the Burden of Disease Especially Among Vulnerable Segments of the Population

34. Preventive healthcare services focusing on child immunization, reproductive health, malnutrition, communicable diseases, non-communicable diseases and congenital diseases will be strengthened with fully resourced plans.
35. Expanded Programme on Immunization (EPI) will respond to the system level challenges by focusing on low performing areas, attempting to reduce dropouts and improving monitoring and supervision systems. Lady Health Workers will be involved to deliver routine immunization services in their catchment areas. Department of Health will provide all resources for implementing the Comprehensive Multi Year Program for EPI in the province.
36. Prevention from common diseases through promotion, early detection followed by subsidized curative support will be an essential part of design of all programmes in health.
37. Control of infectious diseases especially diarrhoea & respiratory tract infections in children, measles, malaria and tuberculosis will be an important priority. Integrated Management of Neonatal and

Childhood Illness (IMNCI) strategy, will be implemented in all health facilities.

38. Safe Blood Transfusion services will be made available to the people of Khyber Pakhtunkhwa through Safe Blood Transfusion Programme. Network of Hospital Blood Banks linked to Regional Blood Centres will be established.
39. The Department of Health will develop a practical programme with an objective of improving the nutrition status of women of childbearing age and children below 3 years by improving the coverage of cost-effective nutrition interventions.
40. Government of KP will implement all provisions of the Public Health (Surveillance & Response) Act 2017 including a functional Public Health Committee formed under the Act.
41. Polio eradication will remain the priority of the government and efforts will be made to interrupt its transmission.
42. To address the growing burden and spread of infectious diseases like Hepatitis B & C, and HIV/AIDS etc.; the Department of Health will focus on primary prevention through, awareness raising, expanding immunization for Hepatitis B in children, vaccination of high-risk groups, screening and ensuring provision of safe blood.
43. Non-Communicable Diseases including mental disorders Control strategies will be implemented focusing on accessible primary prevention, reducing risky behaviours including smoking, unhealthy life styles and dietary habits through health promotion and an intersectoral approach.
44. Oral and dental health is a key element of overall health; therefore, oral health will be integrated into NCD strategies.
45. Communication strategy will be developed to promote synergies in efforts for health promotion, behaviour change to strengthen advocacy for health-promoting activities aimed at preventing increased burden of non-communicable conditions.
46. Government of Khyber Pakhtunkhwa will continue to provide funds for free treatment of cancer and diabetes.
47. Due to very high prevalence of breast cancer; implementing strategies for its comprehensive control will be a high priority for the Department of Health, KP. A programme for screening including Mammography will be established.
48. The Mental Health and Psychosocial Support Services (MHPSS) initiative will be expanded in scope and coverage.

49. The Department of Health will strengthen and implement Integrated Disease Surveillance and Response (IDSRs) by establishing operational surveillance units at all levels with skilled staff and backup networks of laboratories, ensuring Pakistan fulfil the requirements in line with International Health Regulations. As the system develops, existing disease specific surveillance activities will be integrated along with options to include MCH surveillance and NCD behaviours.
50. The scope of public health interventions will be broadened to address newly emerging diseases.
51. Telemedicine will be promoted in the province for transferring health knowledge and skills from category A hospitals to secondary level hospitals and primary care level facilities, especially in remote areas. This will also help in establishing linkages among international hospitals, tertiary level hospitals and districts for better provision of service delivery.
52. Develop strategies to mitigate effects of climate change on human health and health sector according to the Climate Change Policy for KP.
53. The Department of Health shall work with Communication and Works Department to develop guidelines and architectural plans for upgrading and establishment of health facilities to enhance efficiency and effectiveness of infrastructure. All new hospitals and other health facilities shall provide and maintain a safe environment for patients, personnel and public. Buildings shall be designed so that have recommended hazard mitigation measures for risk reduction. In addition, health facilities shall address barriers patients with disabilities face in getting access to health facilities.

4.3 Improved Human Resource Management

54. The Department of Health Khyber Pakhtunkhwa remains committed to achieve the National Human Resources for Health Vision 2018 – 30.
55. A strategic plan for implementing the HRH Vision will be developed and implemented in KP to address workforce shortage with quality production, equitable distribution, enhanced productivity and an improved working environment.
56. HRH Database as part of the Human Resources Management Information System (HRMIS) linked to a central registry will be established in the Department of Health KP.
57. Continuous Professional Development will be institutionalized across both public and private sectors in conjunction with professional

associations and will be linked to re-licensing of the health professionals.

58. Training Institutes shall develop and provide compulsory induction, promotional and refresher courses under supervision of Provincial Health Services Academy (PHSA) and Divisional Health Development Centres (DHDC). These should include knowledge on government rules and regulations, essential functions to be performed, job descriptions, communication and ethics, and guidelines for national and international commitments e.g. SDGs.
59. Develop and implement a competency based curriculum at all levels. The Department of Health will direct and facilitate the respective institutions/bodies in reorienting their curricula and training to being competency based, with enhanced exposure to the community, and with responsiveness to local needs and compliance with international standards.
60. Enhancement in Health Professional Allowance (HPA) will be revised and rationalised by linking it to geographical location, training, post-graduate training, Advance Trauma Life Support (ATLS), Basic Cardiac Life Support (BCLS), Performance and Length of service etc. With HPA, dual job holdings will be discouraged other than institutional practice after working hours in public sector health facilities.
61. Department of Health shall develop budget and guidelines to provide HPA for other cadres of staff.
62. In collaboration with Khyber Medical University and PMDC, shortages in medical specialities like Anaesthesiology, Accident and Emergency (Emergency physicians), Radiology, Pathology, Psychiatry, Forensic Medicine that are “unattractive” for medical graduates will be overcome by initiation of MD/MS training. Incentives may be offered for training in such specialities.
63. Women friendly working environment in all Department of Health facilities and institutions will be facilitated to the maximum within the framework of service rules. Training on workplace harassment, violence, ethics, patients’ rights and staff responsibilities will be made mandatory for all employees. Women friendly working environment in all department of health facilities and institutions will be facilitated to the maximum.
64. Responsive management will be introduced in the Department of Health, with Performance Management System providing incentives to boost performance. Job descriptions for all cadres of staff in the DOH will be revised and updated to promote systematic HR Management with clear roles, functions, line of reporting etc.

65. Priority would be given to enhance capacity in the province for education and training of nurses, LHVs, midwives, pharmacists, allied health workers/paramedics. For example, LHVs will be trained to provide counselling on birth spacing and family planning and roles and responsibilities for LHWs will be reviewed with a focus on improving coverage, nutrition intervention, family planning and child health outcomes.
66. Continuing medical education, with links to promotions in medical, nursing and paramedical education at all levels will be introduced.
67. Medicolegal cases (MLC) have frequently to be dealt by Medical staff in various health facilities, for which they do not have adequate training. DOH will work with police, law department and PHSA to develop training programmes in this important and sensitive area of medical practice. As a general guideline, however it will be ensured that in emergencies, resuscitation and stabilization of the patient will be carried out first and medicolegal formalities may be completed subsequently.
68. KP Resuscitation Council will be established in the province to provide trainings and accreditation in courses on basic & advanced life support.
69. Quality of nursing will be improved gradually by making B.Sc. in Nursing a standard requirement for nurses and attainment of a range of post-graduate nursing qualifications. Nursing teaching cadre will also be strengthened through accelerated programmes and incentives.
70. Government shall develop strategy to encourage establishment of Pharmacists, paramedical and nursing training institutions in private sector.
71. Department of Health will establish paramedic examination/licensing board in the province in consultation with the Federal Ministry of National Health Services, Regulations and Coordination.
72. The roles, responsibilities and functions for Lady Health Workers would be reviewed, while ensuring maximum possible coverage in the province especially in the rural and hard to reach areas. Further increase in number of LHWs will be decided as part of a rationalisation exercise.

4.4 Improved Governance, Regulation and Accountability

73. The Department of Health and its staff shall be accountable to the government and citizens of Khyber Pakhtunkhwa for providing health services which meet the established service standards and serve the target population.

74. Roles and responsibilities of the Department of Health will be reviewed and restructured with responsibility for leading on technical issues, revision and implementation of health-related laws and disease surveillance as well as for improved functioning at the provincial and district level.
75. Stewardship role of the Department of Health will be strengthened and institutionalized. Department of Health will be responsible for sector wide strategic planning, regulation, purchasing and financing and moving towards separation of service provision from its stewardship function. Day to day management of health programmes will be passed on to DGHS Office, district offices and MTIs etc.
76. Informed decision making will be promoted in the Department of Health. Platforms at provincial level for transforming evidence into policy advice will be established as “Knowledge Management Centre” based in HSRU.
77. There will be a renewed and synergistic focus on cross-sectoral action for advancing health, with a particular focus on communicable and non-communicable diseases including mental health and under-nutrition. The concepts of “One Health” and “Health in all policies” will be promoted.
78. Government will strive to develop a common vision, framework and a platform with multiple stakeholders from across the sectors to work for health promotion, for instance, education, food security, agriculture and livestock, housing, sanitation, water, environment, IT, local government, social welfare, law enforcement etc.
79. In order to gear up its efforts towards SDGs. Government will embark upon planning, legislation, regulation, behavioural change communication, information exchange, and evidence-based decision through joint efforts of different sectors.
80. Health Management Committees were constituted through an administrative order of the Government of Khyber Pakhtunkhwa to oversee health care delivery at the District Hospital level. These committees will be made functional and effective to oversee health care delivery at the District Headquarter Hospital level.
81. Health Management Committees will be formed at the Union Council level to oversee healthcare delivery at primary healthcare facilities. It will be comprising of community members, including female representatives, and will be reporting directly to the Ministry of Health with all their complaints, concerns and recommendations.
82. District Advocacy Forums and a Provincial Advocacy Forum will be established comprising of committed accountability champions, and influential members of civil society to regularly interact with the

Department of Health for resolving issues faced by community members.

83. Community engagement and awareness will be strengthened through outreach health staff, health campaigns at primary health facilities, social media campaigns, complaints cell and health management committees.
84. Office of the Minister of Health will be linked to an organized, responsive, transparent and effective complaint cell. This complaint cell will have functional complaint redressal mechanisms with provision of logging and follow up of all complaints.
85. All transactions and official correspondence related to the Department of Health as well as operations and service data will be digitalized with a centralized database.
86. Formal mechanisms and protocols will be developed for the public and private hospitals to report statistics/data on incident reporting, including, but not limited to "Adverse Events", such as events related to medication, patient care, surgery or procedures and death.
87. Steps will be taken to prioritize deployment of information technology to the maximum, whenever feasible, to improve efficiency, delivery of health services, manage accountability and improve governance.
88. Role of the Health Foundation will be reviewed and strengthened with the objective to finance private health sector for provision of priority services particularly in the rural areas.
89. Health Care Commission (HCC) KP being a legal body for measuring the quality of health care both in public and private sector; Department of Health will assess, review and strengthen Health Care Commission to streamline its functions. After reviewing and revising previously approved and notified quality management & assessment standards in 2015 for public and private sector which have not been executed yet, HCC will be enabled to implement all the updated regulations.
90. Regulation pertaining to minimum pertaining to minimum quality standards and licensing requirements, for both public and private health institutions, including hospitals, nursing homes, maternity home, medical/consulting clinic, dental clinics, clinical laboratory, x-ray clinics, all other diagnostic facilities, blood banks, psychiatry clinics, operation theatres - will be reviewed, revised and developed. Effective implementation and enforcement plans will be put in place to make sure that accurate diagnosis and assessment of health and subsequent most suitable prevention and/or treatment of disease is being carried out.
91. Private sector including NGOs will be mainstreamed into the development process by harnessing their potential to deliver

services. The government will further promote the role of the private sector in the delivery of health services, with attention to quality and patient safety and safeguarding the interests of the poor and marginalized.

92. All recruitments will be on merit and it will be ensured that an internal/external competitive and transparent process is followed to select project managers, DHOs and other management staff.
93. Details of all health staff will be computerised including information on transfer and posting to implement tenure surety.
94. Implement the quality enhancement strategy for health facilities in a phased manner in all districts over the next five years.
95. Minister's Task Force will be commissioned to periodically study, research and identify issues in the health system.
96. Health Technology Assessment (HTA) capacity will be created at provincial and district level. Government will be vigilantly monitoring the selection, quality, price and use of technologies, equipment and medicine, as per international standards.
97. Rational use of drugs will be promoted, through legislation if needed, to check excessive prescription of drugs by doctors and to limit over the counter drug availability.
98. Efficient supply management system will be developed to store and transport medicines at provincial, district and facility level.
99. Department of Health will formulate the legal framework, policies and procedures for strengthening the pharmaceutical and supplies management system.
100. Drug testing laboratories will be strengthened and Appellate Laboratory will be established.
101. Standard pharmaceutical practices including promoting the use of generic drugs in both public and private sectors will be implemented. This will include purchasing and promoting generic drugs for the public health facilities.
102. Enhancement of food safety in collaboration with Food Safety & Halal Food Authority in KP will be ensured.
103. The MTBF will be fully implemented at the provincial and district level, as a step to enhance ability for planning well in advance and linking funds to objectives.
104. It will be ensured that policy, resource allocation and flow of funds demonstrably shall match the needs of target populations ascertained by the DHIS and other programme MISs.

4.5 Enhanced Health Financing for Efficient Service Delivery & Financial Risk Protection for People of KP

105. Health financing strategy will be developed for the province to progressively build a sustainable political, national, and community commitment with a view towards achieving and maintaining universal health coverage through increased and diversified domestic financing options.
106. Public sector health care financing will be scaled up using predominantly tax-based revenues managed under the health financing strategy for the province.
107. The DOH will agree on mechanisms with the BISP, Zakat, Baitul Maal and other Poverty Reduction programmes in the province to ensure efficient and effective use of funds for healthcare under these programmes.
108. Public sector financing will be augmented by more effective use of development aid and accessing more financial support from global initiatives, bilateral and multilaterals.
109. The government of Khyber Pakhtunkhwa is committed to reducing out of pocket expenditures for health especially by the poorest. Social Health Protection Initiative launched to increase access of poor and marginalized community to quality health care services will be further strengthened.
110. The Department of health will strive to ensure that all citizens living below poverty line have access to Sehat Sahulat card. It will work on expanding access by distributing additional Sehat Sahulat cards and eventually extending Sehat Sahulat card access to newly merged (erstwhile FATA) districts. It will work with private insurance companies to assess health care coverage options for rest of the population.
111. Budget for health will be reviewed to rationalize allocations for tertiary, secondary and primary health care levels and services. Gradually current budget will be balanced development budget as well as between salary and non-salary components.
112. Provincial taxes shall be applied on products with adverse effects on health. These would include higher taxes on tobacco products and on sugary drinks. punitive measures against industrial waste, dangerous levels of emissions, non-conforming health establishments and suppliers. The revenue generated from these taxes should be provided to the Department of Health as additional support for provision of health care.

113. Different models of health financing shall be piloted to support existing budgets. One model could be voluntary purchase of health insurance by general public. Health Insurance companies will be encouraged to introduce health insurance products for voluntary purchase.
114. Explore opportunities for promotion of “health tourism” in the province especially focusing on the neighbouring Afghanistan and central Asian states.

5 Oversight, Monitoring and Evaluation Mechanism for KP Health Policy

In many countries, policies are developed with limited implementation. In order to ensure implementation of the Health Policy in Khyber Pakhtunkhwa, the government will put in place mechanisms for effective oversight and facilitation of the process.

To ensure implementation, detailed activity and project plans will need to be designed and PC-1s prepared to secure the technical, human and/or financial resources required.

The Health Sector Reform Unit will be the entity responsible to facilitate implementation of the Policy. The aim of HSRU is to facilitate implementation of the prioritized reform areas as well as to act as a Policy Advisory Unit of the Health Department. In this function, the HSRU will work directly under the office of the Minister for Health.

The Department of Health will solicit financial and technical support from development partners to support the Unit in effective oversight, monitoring and evaluation of the Policy implementation. The support solicited will be to:

- Place technical experts for support in key areas.
- Periodic evaluation of the process which may include assessments at district & community level.
- Support preparing Policy Briefs for decision making on important matters.
- Develop and advise Department of Health on Change Management for reform of the health sector.

After the approval of the Health Policy, a Strategic Plan will be developed by December 2018 which will outline key strategies to ensure key actions are undertaken. The Strategic Plan will have cost estimates. A monitoring and evaluation (M&E) mechanism will be developed for the Health Policy. The M&E mechanism will facilitate assessment of progress towards fulfilling the outcomes outlined in the health policy. A set of indicators will be included in the M&E mechanism.

A “Health Policy Coordination Committee” will be established under the chairmanship of Health Minister with representations from Finance Department, P&DD, Population Welfare Department, Public Health Engineering, Local Government, Law, Education and Social Welfare departments in addition to Secretary Health, DGHS and Chief HSRU. This committee will ensure support and coordination of different sectors for implementation of health policy, moving towards ‘Health in All Policies’ and promoting inter-sectoral linkages.

The Health Policy Advisory Council will be strengthened to provide technical backstopping to the health policy implementation.

An oversight mechanism on the pattern of the KP Health Roadmap can be adopted, whereby progress of implementation of the Health Policy shall be reviewed in stock take meetings of the HPAC held every two months, presided over by the Minister of Health.

Minister of Health Khyber Pakhtunkhwa, in consultation with Health Policy Coordination Committee and HPAC can constitute other committees/sub-committees with specific mandate that would either facilitate implementation of health policy or review and monitor the progress of implementation.